SAULT AREA HOSPITAL / HÔPITAL DE SAULT-SAINTE-MARIE | iCare

DEMOGRAPHIC LABEL

OUTPATIENT MENTAL HEALTH SERVICES REFERRAL (SAH INTERNAL)

Completed by: _____

** Referring PSYCHIATRIST: _____ Date: ___ /____ /____
dd / mm / yy

SA# _____

SERVICES:

☐ Nursing (Advise patient to bring in all medications for appointment)

☐ Psychotherapy

PLEASE ATTACH:

☐ Admission Assessment/Crisis Note

☐ Consultation Summary

☐ Discharge Summary

PSYCHIATRIC DIAGNOSIS: _____

PRIMARY PRESENTING ISSUES: _____

REASON FOR REFERRAL: _____

Is patient currently in hospital: ☐ Yes ☐ No

Primary Diagnosis of Substance use: ☐ Yes ☐ No If Yes, what is substance of choice: _____

Primary Diagnosis of Problem Gambling, Gaming and/or Technology use: ☐ Yes ☐ No

Hx of Aggression/Violent Behaviors: ☐ Yes ☐ No If Yes: _____

MEDICAL CARE PROVIDER INFORMATION:

Psychiatrist: _____

Primary Care Provider: _____

Other Service Providers: _____

----------OPMHS USE ONLY----------

Date Received: _____

1st Apt Scheduled with: _____Date: ___ /____ /____
dd mm yy

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